STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415073	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jeanne Jugan Residence	964 Main Street Pawtucket, RI 02860

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on surveyor observation, record review, and staff interview, the facility failed to maintain a safe, functional, and comfortable environment for residents, staff, and visitors relative to 1 of 1 laundry room observed.Findings are as follows:Review of an undated facility policy titled, Dryer Care Policy states in part, .Lint screen is installed in the bottom compartment of all commercial dryers.These lint screens must be brushed and cleaned. If not the screen will become packed with lint. When this occurs, the warm air moving through the system is blocked, raising the temperature in the basket and causing a potentially dangerous situation, ie fire.Lint screens must be brushed and cleaned every 2 or 3 loads to maintain proper airflow and prevent overheating.Staff will be present when dryers are in operation.During a surveyor observation and simultaneous interview on 4/1/2026 at 12:03 PM of the laundry room, in the presence of the District Manager, revealed two large Electrolux Professional dryers in operation without staff present. The District Manager indicated that the Housekeeper, Staff E, was on break.During a subsequent surveyor observation at approximately 12:10 PM in the presence of Staff E and the District Manager, revealed the lint traps for both dryers were noted to be covered in a thick blanket of white lint covering the entire mesh lint screen.Review of a DRYER TRAP CLEANING SCHEDULE document, which was reviewed at 12:11 PM, revealed the lint screens were documented as cleaned on 4/1/2026 at 8:00 AM, 10:00 AM, 12:00 PM, and 2:00 PM by Staff E.During a surveyor interview on 4/1/2026 at approximately 12:15 PM with Staff E, via the assistance of the District Manager as an interpreter, she revealed that she last cleaned the lint screens at 10:00 AM and acknowledged that she had not cleaned either lint screen at 12:00 PM, as documented. Additionally, she acknowledged that she prematurely documented that she cleaned the lint screen at 2:00 PM. Further, she revealed that she had dried three loads of laundry prior to the current load (fourth load) that was being dried since she last cleaned the lint screen at 10:00 AM.During a surveyor interview immediately following the above interview with the District Manager, he revealed that Staff E should not sign off the dryer trap cleaning log in advance and would have expected the lint screen to have been cleaned at 12:00 PM, as documented.During a surveyor interview on 4/2/2026 at 12:35 PM with the Maintenance Director, he revealed that he would expect that staff would follow the facility's policy relative to laundry services.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415073	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jeanne Jugan Residence	964 Main Street Pawtucket, RI 02860

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review and staff interview, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by the Facility Assessment, for 2 of 5 nurses reviewed for wound care competencies. Findings are as follows:Review of the Facility Assessment last revised in January of 2026 revealed that nursing competencies were verified upon orientation, annually at minimum, and as indicated for all staff as needed. The Facility Assessment further revealed that they provide care and services based on the needs of their resident population which includes residents who require wound care.Review of the resident roster revealed one resident, presently residing in the facility that requires daily wound care for a Stage IV pressure ulcer (the most severe form of a pressure ulcer, involving full-thickness tissue loss with exposure of the muscle, tendon, ligament, cartilage, or bone, primarily caused by prolonged pressure over a bony prominence).Review of the following nursing personnel files failed to reveal evidence that they had received training in wound care or that they were competent in providing wound care services: - Registered Nurse, Staff A with a hire date of April 24, 2015,- Licensed Practical Nurse, Staff B with a hire date of May 28, 2024.During a surveyor interview with the Director of Nursing Services on 4/1/2026 at 11:38 AM, she was unable to provide evidence that all nursing staff were competent in providing wound care.

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NAME OF PROVIDER OR SUPPLIER: Jeanne Jugan Residence		STREET ADDRESS, CITY, STATE, ZIP CODE: 964 Main Street, Pawtucket, RI 02860	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on surveyor observation, clinical record review, and staff interview, the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections, relative to staff wearing the appropriate personal protective equipment for Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce the transmission of multidrug-resistant organisms [MDROs] in nursing homes), for 1 of 1 resident observed being assisted with a transfer, Resident ID #5.Findings are as follows:Review of the facility policy titled, Enhanced Barrier Precautions Policy dated 1/2026 states in part, .Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of Multidrug Resistant Organisms .Residents in nursing facilities are particularly vulnerable to colonization and infection with MDROs, which can lead to limited treatment options and adverse health outcomes.Nursing staff initiates EBP for residents with.Wounds.even if the resident is not known to be infected or colonized with an MDRO.Record review revealed Resident ID #5 was admitted to the facility in June of 2021, with diagnoses including, but not limited to, dementia and a stage 4 pressure ulcer (the most severe form of a pressure ulcer, involving full-thickness tissue loss with exposure of the muscle, tendon, ligament, cartilage, or bone, primarily caused by prolonged pressure over a bony prominence) to his/her right ankle.During surveyor observations on all days of the survey, 3/30/2026 through 4/2/2026, a sign was posted by the resident's door indicating that the resident required EBP.Review of the EBP sign revealed that everyone must clean their hands, including before entering, and when leaving the room. Further review revealed providers, and staff must also wear a gown and gloves for high-contact activities, including transfers.During a surveyor observation on 3/31/2026 at 11:32 AM, Nursing Assistant (NA), Staff C, entered Resident ID #5's room without performing hand hygiene or putting on a gown or gloves. Staff C then applied a gait belt to the resident, assisted him/her with a transfer into a wheelchair, removed the gait belt, and positioned the resident with pillows behind his/her back. Staff C then entered the resident's bathroom, turned the water on and then immediately off, prior to exiting the room. Staff C failed to perform hand hygiene upon exiting the room. During a surveyor interview with Staff C, immediately following the above observations, she indicated that she does not usually put on a gown or gloves when assisting the resident with transfers. Additionally, she acknowledged that she failed to perform hand hygiene before entering or when exiting the resident's room. During a surveyor interview on 3/31/2026 at 11:54 AM with Licensed Practical Nurse, Staff D, she revealed that Resident ID #5 requires EBP due to having a wound on his/her ankle and that staff should follow the precaution signs that are posted. She further revealed that she would expect staff to perform hand hygiene when entering and exiting the resident's room, and to wear a gown and gloves when assisting the resident with transfers. During a surveyor interview on 4/1/2026 at 10:20 AM with the Infection Preventionist, she revealed that Resident ID #5 requires EBP related to his/her wound. Additionally, she indicated that she would expect staff to perform hand hygiene before entering and when exiting a resident's room, and to wear a gown and gloves for transfers when EBP is required. During a surveyor interview on 4/1/2026 at 12:53 PM with the Director of Nursing Services, she revealed that staff are expected to wear a gown and gloves when transferring a resident who requires EBP.